South Cove Community Health Center
SCCHC Information Systems Request Form

By default, users are granted the most restrictive level of access. All accounts unused for 180 days or more will be disabled. Access can only be restored by completing this form.

Requests will be processed within 3 business days of receipt. Fax requests to 617-521-6799

To be completed by requestor (Please print clearly and fill out for **completely**) Date of Request: _____

Type of Request: ___ New account ___ Disable Account ___ Re-enable Account ___ Other

Personnel Information:

Name: _____
Last Name *First Name* *Middle Initial*

Title: _____

Department: _____

Date of Birth: _____ **SSN:** (Last 4 digits ONLY) _____ **Gender:** ___Male ___Female

Employee Type: ___ Full-Time ___ Part-Time ___ Per-Diem ___ Temp/Contract *Employee Begin Date* _____ *Employee End Date* _____

Work Phone: _____

Site: ___ Washington Street ___ Quincy (Hancock Street) ___ Quincy (Holmes Street) ___ South Street
___ Other: (Specify)_____

Access Requested:

____Network Account

___ Email Account

___ ECW: ___ General Dept Access – Dept. Name/Role: _____
___ Specific Additional Security Access – Please specify: _____

___ Other – Please Specify: _____

Computer Name: _____
(There should be a white label on the front of the computer with the name on it, if not call IS dept for help)

To Be Completed By: **Authorizing Department Manager (Please print clearly and fill out completely)**

Name: (Please Print): _____
Last Name *First Name* *Middle Initial*

Department: _____ **Work Phone:** _____

Signature: _____

Note: Once processed, a call will be placed to the number given on the form, updating the status, and/or granting a log-in name and/or password if necessary.

Request processed by:_____

Date:_____

Confidentiality Acknowledgement

Any information learned during the performance of one's work at South Cove Community Health Center or any of its affiliates (hereinafter "SCCHC") which is not commonly available to the public must be kept confidential. This applies to information about patients, employees, and medical staff, research and business affairs. Further this applies to information in any form –spoken, written or electronic.

Each Individual working in the SCCHC environment is responsible for protecting the privacy of our employees, our staff, and our patients, and must take care to preserve confidentiality in conversations and in handling, copying, faxing, and disposing of documents. Unusual activity or behavior, which could threaten confidentiality, should be questioned and reported.

Access to SCCHC information is permitted only as required for the performance of one's job. For example, reading confidential information not directly required for job performance, even if that information is not further disclosed, is a violation of policy and is, therefore strictly prohibited. All policies and procedures related to authorization and access of confidential information must be followed.

Only people with an officially granted account may access SCCHC computer systems and networks requiring passwords. Each person is responsible for maintaining confidentiality by never sharing passwords or access and by always locking or logging off a terminal or workstation when leaving the area. Each person is accountable for all activity occurring under his/her account, password, and/or electronic signature. Such activity may be monitord.

Disclosure of SCCHC confidential information is prohibited except when required for the performanceof one's job for SCCHC and when specifically authorized. Disclosure of confidential information is prohibited indefinitely, even after termination of employment or business relationship, unless specifically waived in writing by an authorized party.

I certify that I have received and read this confidentiality acknowledgement and understand the requirements set forth in it. I understand that I will be subject to disciplinary action, up to and including termination of my employment, professional privileges, and business relationships for violating SCCHC policies or failing to report violations of SCCHC policies.

_____	_____
Printed Name	Title
_____	_____
Signature	Date
_____	_____
Supervisor's/Sponsor's Printed Name	Title
_____	_____
Supervisor's/Sponsor's Signature	Date